FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020404

Facility Name: WILLIAM L DAWSON NURSING HOME

Address: 3500 S GILES (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (312) 326-2000 **Fax #** (312) 326-5270

IDPA ID Number: 36-2477301

Date of Initial License for Current Owners: 1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) PAMELA ORR
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	97		3,227	3,324	8
9	SNF/PED					9
10	ICF	57,826	2,692		60,518	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,923	2,692	3,227	63,842	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.20%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started / / 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 3,227

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	364,036	75,878	21,135	461,049		461,049		461,049			1
2	Food Purchase		371,933		371,933	(68,954)	302,979	(2,719)	300,260			2
3	Housekeeping	83,557	49,806		133,363		133,363		133,363			3
4	Laundry	128,351	38,197	8,905	175,453		175,453		175,453			4
5	Heat and Other Utilities			224,309	224,309		224,309		224,309			5
6	Maintenance	211,387	27,143	102,500	341,030		341,030	(3,259)	337,771			6
7	Other (specify):*			57,237	57,237		57,237		57,237			7
8	**TOTAL General Services**	787,331	562,957	414,086	1,764,374	(68,954)	1,695,420	(5,978)	1,689,442			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	2,636,171	170,618	12,663	2,819,452		2,819,452		2,819,452			10
10a	Therapy	17,347	4,096	10,335	31,778		31,778		31,778			10a
11	Activities	101,098	10,939		112,037		112,037		112,037			11
12	Social Services	104,751			104,751		104,751		104,751			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,859,367	185,653	27,798	3,072,818		3,072,818		3,072,818			16
	C. General Administration											
17	Administrative	352,739			352,739		352,739	(50,824)	301,915			17
18	Directors Fees											18
19	Professional Services			165,303	165,303		165,303	(44,258)	121,045			19
20	Dues, Fees, Subscriptions & Promotions			44,146	44,146		44,146	(23,390)	20,756			20
21	Clerical & General Office Expenses	274,072	44,446	63,477	381,995		381,995	(10,845)	371,150			21
22	Employee Benefits & Payroll Taxes			961,352	961,352	68,954	1,030,306	(2,640)	1,027,666			22
23	Inservice Training & Education			1,070	1,070		1,070		1,070			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,343	1,343		1,343		1,343			25
26	Insurance-Prop.Liab.Malpractice			183,624	183,624		183,624		183,624			26
27	Other (specify):*			120,000	120,000		120,000	(120,000)				27
28	**TOTAL General Administration**	626,811	44,446	1,540,315	2,211,572	68,954	2,280,526	(251,957)	2,028,569			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,273,509	793,056	1,982,199	7,048,764		7,048,764	(257,935)	6,790,829			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WILLIAM L DAWSON NURSING HOME #0020404 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	17,720	
	REPAIRS & MAINTENANCE		3,415	
			0	21,135
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		8,905	
			0	8,905
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		116,913	
	ELECTRICITY		81,116	
	WATER		23,940	
	CABLE TV - LOBBY		2,340	
			0	224,309
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		3,911	
	BUILDING REPAIRS		3,934	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		54,260	
	ELEVATOR MAINTENANCE & REPAIR		10,744	
	OUTSIDE LABOR		10,617	
	EXTERMINATING SERVICE		9,570	
	FIRE SERVICE		4,101	
	AMORT - DEFERRED DECORATING		5,363	
			0	
			0	102,500
7	**OTHER**			
	SCAVENGER		19,943	
	SECURITY SERVICE		37,294	57,237
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,800	4,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,640	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	9,023	
			0	
			0	12,663
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		1,437	
	SPEECH THERAPY SERVICES		4,087	
	OCCUPATIONAL THERAPY SERVICES		1,278	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,594	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,939	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	10,335
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME #0020404 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,868	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	156,435	
			0	165,303
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,891	
	EMPLOYEE WANT ADS	XIX F	3,238	
	CONTRIBUTIONS	VI 20 XIX F	2,100	
	DUES & SUBSCRIPTIONS	XIX F	13,312	
	LICENSES & PERMITS	XIX F	3,502	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	4,119	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	8,073	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	1,280	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,927	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	704	44,146
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		405	
	EQUIPMENT REPAIR & MAINTENANCE		15,255	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	10,845	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		618	
	TELEPHONE		35,605	
	MESSENGER SERVICE		749	
			0	63,477

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	317,741	
	UNEMPLOYMENT COMPENSATION	XIX D	67,567	
	WORKERS COMPENSATION INSURANCI	XIX D	103,954	
	HOSPITALIZATION INSURANCE	XIX D	430,665	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,840	
	EMPLOYEE PHYSICAL EXAMS	XIX D	101	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	2,640	
	PENSION/PROFIT SHARING PLANS	XIX D	16,324	
	CHICAGO HEAD TAX	XIX D	10,520	961,352
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,070	1,070
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,343	1,343
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		183,624	183,624
27	**OTHER**			
	BAD DEBTS	VI 24	120,000	
				120,000

GRAND TOTAL COLUMN 3 OTHER 1,982,199

WILLIAM L DAWSON NURSING HOME
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	371,933	PATIENT MEALS	191526
LESS SALES TAX	(2,719)	ADD EMPLOYEE MEALS	43920
NET FOOD	369,214	TOTAL MEALS/YEAR	235446
TOTAL PATIENT CENSUS	63,842	NET FOOD	369214
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	235446
TOTAL PATIENT MEALS	191526	COST PER MEAL	1.57
		TIME EMPLOYEE MEALS	43920
ADD # EMPLOYEE MEALS/DAY	120		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	68954
TOTAL EMPLOYEE MEALS	43920		

WILLIAM L DAWSON		
EQUIPMENT RENTAL	PAGE 14 SCHEDULE XI B LINE 16	
12/31/04		
PROFESSIONAL MEDICAL	NURSING EQUIPMENT	744
RH MEDICAL	NURSING EQUIPMENT	1,433
PEL/VIP	NURSING EQUIPMENT	1,785
MEDIQ/PRN	NURSING EQUIPMENT	2,415
JOHNSON	WATER TREATMENT	360
EMPIRE COOLER SERVICE	ICE MACHINE	3,097
HINCKLEY	WATER COOLER	767
PITNEY BOWES	POSTAGE METER	1,650
IMAGISTICS	OFFICE EQUIPMENT	588
MARLIN LEASING	COPIER	2,798
PUBLIC STORAGE	STORAGE	6,633
		22,270

WILLIAM L DAWSON		
PROFESSIONAL FEES	PAGE 21 SCHEDULE XIX C	
12/31/04		
HDSI	DATA PROCESSING	5,099
ACCU-MED	DATA PROCESSING	2,700
MEDI.COM	DATA PROCESSING	70
MEDIFAX-EDI	DATA PROCESSING	207
ADMINASTAR	DATA PROCESSING	792
KBKB	ACCOUNTING	21,000
FR&R	ACCOUNTING	4,000
DISTELDORF LTD	ACCOUNTING	2,035
SACHNOFF & WEAVER	LEGAL	1,642
NEAL GERBER & EISENBERG	LEGAL	15,426
MYERS MILLER & KRAUSKOPF	LEGAL	20,497
GOLD & RATNER	LEGAL	2,312
REAL ESTATE TAX SERVICES	REAL ESTATE LEGAL	9,374
ECONOCARE	PURCHASING CONSULTANT	4,410
EXPERTEK CYBER SOLUTIONS	WEB HOSTING FEE	310
ADVANTAGE MARKETING PROF.	MARKETING - DISALLOWED - SEE PG 5A LINE 3	44,258
LAVERGNE MOMAN	INTERIOR DESIGN	652
MERIT BENEFITS GROUP	401K ADMINISTRATOR	300
CITISTREET RETIREMENT SERVICES	401K ADMINISTRATOR	1,343
FR&R	MED B BILLING	23,875
PEELO & ASSOC	M/C COST REPORTING	5,000
		165,303

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME #0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			117,359	117,359		117,359	80,522	197,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			123,027	123,027		123,027	(12,933)	110,094			32
33	Real Estate Taxes			240,672	240,672		240,672		240,672			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,679	32,679		32,679		32,679			35
36	Other (specify):* MIP INS			8,870	8,870		8,870		8,870			36
37	**TOTAL Ownership**			522,607	522,607		522,607	67,589	590,196			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,406	526,573	678,979		678,979		678,979			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,506	134,506		134,506		134,506			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		152,406	661,079	813,485		813,485		813,485			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,273,509	945,462	3,165,885	8,384,856		8,384,856	(190,346)	8,194,510			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	80,522	30		9
10	Interest and Other Investment Income	(12,144)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,719)	2		13
14	Non-Care Related Interest	(789)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,280)	20		17
18	Fines and Penalties	(10,845)	21		18
19	Entertainment				19
20	Contributions	(7,027)	20		20
21	Owner or Key-Man Insurance	(2,640)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,000)	27		24
25	Fund Raising, Advertising and Promotional	(7,010)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(8,073)	20		28
29	Other-Attach Schedule SEE PAGE 5-A	(98,341)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (190,346)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (190,346)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WILLIAM L DAWSON NURSING HOME

ID# 0020404

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -3259	6	1
2	MARKETING SALARIES	(50,824)	17	2
3	MARKETING CONSULTANT-ADVANTAGE MKT	(44,258)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(98,341)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,719)	0	0	0	0	0	0	0	0	0	0	(2,719)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,259)	0	0	0	0	0	0	0	0	0	0	(3,259)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,978)	0	0	0	0	0	0	0	0	0	0	(5,978)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(50,824)	0	0	0	0	0	0	0	0	0	0	(50,824)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(44,258)	0	0	0	0	0	0	0	0	0	0	(44,258)	19
20	Fees, Subscriptions & Promotions	(23,390)	0	0	0	0	0	0	0	0	0	0	(23,390)	20
21	Clerical & General Office Expenses	(10,845)	0	0	0	0	0	0	0	0	0	0	(10,845)	21
22	Employee Benefits & Payroll Taxes	(2,640)	0	0	0	0	0	0	0	0	0	0	(2,640)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	27
28	**TOTAL General Administration**	(251,957)	0	0	0	0	0	0	0	0	0	0	(251,957)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(257,935)	0	0	0	0	0	0	0	0	0	0	(257,935)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	80,522	0	0	0	0	0	0	0	0	0	0	80,522	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,933)	0	0	0	0	0	0	0	0	0	0	(12,933)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	67,589	0	0	0	0	0	0	0	0	0	0	67,589	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(190,346)	0	0	0	0	0	0	0	0	0	0	(190,346)	45

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	PAMELA ORR	ADMINISTRATOR	ADMIN	100%	NONE	40	100.00	SALARY	$ 148,049	17-1	1
2	MARJORIE MARTIN	ASST ADMIN	ADMIN	BY	" "	40	100.00	" "	55,247	17-1	2
3	CHERYL MARTIN	CONTROLLER	ACCOUNTING	ATTRIBU-	" "	40	100.00	" "	138,078	21-1	3
4	ROBYN MARTIN	ASST ADMIN	ADM/EMPL REL	TION	" "	20	50.00	" "	50,825	17-1	4
5	" "	ASST ADMIN	MARKETING**	" "	" "	20	50.00	" "	50,824	17-1	5
6	SHERRIE MARTIN	MED RECORDS	MED RECORDS	" "	" "	40	100.00	" "	17,739	10-1	6
7											7
8											8
9			** DISALLOWED ON PAGE 5A LINE 1								9
10											10
11											11
12											12
13								TOTAL	$ 460,762		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	REILLY MORTGAGE		X	MORTGAGE	$17,746.00	10/31/75	$ 2,622,700	$	10/31/16	7.7500	$ 44,365	1
2	REILLY MORTGAGE		X	MORTGAGE	$11,475.49	03/16/04	1,792,800	1,770,175	03/16/28	5.8200	73,817	2
3	AMORTIZATION-LOAN FEES		X	AMORTIZATION OVER LIFE OF LOAN 288 MONTHS			56,710	54,741			1,969	3
4												4
5												5
	Working Capital											
6	INSURANCE FINANCING		X	INSURANCE FINANCING							2,087	6
7												7
8												8
9	TOTAL Facility Related				$29,221.49		$ 4,472,210	$ 1,824,916			$ 122,238	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							789	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 789	14
15	TOTALS (line 9+line14)						$ 4,472,210	$ 1,824,916			$ 123,027	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 8,870 Line # 36-3

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 306,490	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 272,222	2
3. Under or (over) accrual (line 2 minus line 1).		$ (34,268)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 274,940	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 240,672	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	314,872	8
	2000	292,487	9
	2001	300,094	10
	2002	303,459	11
	2003	272,222	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLIAM L DAWSON NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0020404

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-34-310-002-0000	NURSING HOME	$ 2,981.05	$ 2,981.05
2.	17-34-310-003-0000	NURSING HOME	$ 1,458.49	$ 1,458.49
3.	17-34-310-004-0000	NURSING HOME	$ 1,406.45	$ 1,406.45
4.	17-34-310-055-0000	NURSING HOME	$ 265,449.32	$ 265,449.32
5.	17-34-310-056-0000	NURSING HOME	$ 231.65	$ 231.65
6.	17-34-310-057-0000	NURSING HOME	$ 463.30	$ 463.30
7.	17-34-310-058-0000	NURSING HOME	$ 231.65	$ 231.65
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 272,221.91	$ 272,221.91

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 4 + BASEMENT

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	39,156	1974	$ 149,500	1
2	PARKING LOT			11,683	2
3	TOTALS	39,156		$ 161,183	3

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1975	1974	$ 955,670	$ 19,113	30	$ 31,856	$ 12,743	$ 939,751	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	COMPONENTS			1975	1,228,016		30	40,934	40,934	1,200,887	9
10	ELEVATOR			1975	97,338		20			97,338	10
11	SPRINKLER			1977	9,699		20			9,699	11
12	FREEZER REPAIRS *			1984	33,981		20	801	801	33,981	12
13	LINEN CHUTES			1985	1,925		15			1,925	13
14	ROOF REPAIRS			1985	32,489		20	1,624	1,624	31,668	14
15	AIR LOUVERS			1986	2,156	114	20	108	(6)	1,998	15
16	BRAILLE PLATES			1986	2,150	113	15		(113)	2,150	16
17	REG. VALVE			1987	2,760	88	20	138	50	2,358	17
18	BUILDING IMPROVEMENTS			1988	2,257	118	20	113	(5)	1,867	18
19	BUILDING IMPROVEMENTS			1990	5,052	160	20	253	93	3,577	19
20	BUILDING IMPROVEMENTS			1990	2,416	77	15	161	84	2,308	20
21	BUILDING IMPROVEMENTS			1991	12,963		15	864	864	11,314	21
22	BUILDING IMPROVEMENTS			1992	24,808	788	20	1,240	452	15,071	22
23	BUILDING IMPROVEMENTS			1993	13,446	345	30	448	103	5,152	23
24	BUILDING IMPROVEMENTS			1994	6,469	165	39	166	1	1,784	24
25	PARKING LOT REPAIRS			1994	15,295	1,020	15	1,020		10,709	25
26	WALK-IN FREEZER REPAIRS			1995	2,510	64	39	64		728	26
27	PLUMBING REPAIRS			1995	21,850	560	39	560		5,250	27
28	DOORS/FASCIA			1995	3,872	99	39	99		929	28
29	CEILING TILE			1995	90,187	2,312	39	2,312		20,989	29
30	CONCRETE REPAIRS			1995	4,309	287	15	287		2,726	30
31	DRYWALL/COUNTER TOPS/CABINETS/TILE			1996	2,251	58	39	58		510	31
32	ELEVATOR REPAIR			1996	6,833	175	39	175		1,510	32
33	ELEVATOR DOOR REPAIRS			1998	4,517	116	39	116		797	33
34	FIRE SYSTEM UPGRADE			1998	3,193	82	39	82		509	34
35	CONCRETE REPAIRS			1998	19,117	490	39	490		3,042	35
36	ROOF REPAIRS			1998	21,150	542	39	542		3,275	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LAUNDRY ROOM/DAMPERS/PATIO REMODELLING	1999	$ 30,264	$ 776	39	$ 776	$	$ 4,594	37
38	DOORS/LOCKS/ELEVATOR REPAIRS	1999	14,549	373	39	373		2,080	38
39	LAUNDRY RM/HEAT-COOL/CABINETS/LOCKS/AWNING	1999	26,503	680	39	680		3,689	39
40	PLUMBING REPAIRS/FIRE SAFETY UPGRADE/LOCKS	1999	56,650	1,453	39	1,453		7,622	40
41	EMERGENCY ELECTRICAL OUTLETS/FIRE DAMPERS	1999	51,364	1,317	39	1,317		6,741	41
42	ALARM SYSTEM UPGRADE	2000	130,975	3,358	39	3,358		14,437	42
43	PARKING LOT RAMP / STONE WALL	2000	24,335	624	39	624		2,900	43
44	DISINFECTION SYSTEM / BOILERS / ELECTRICAL	2000	47,713	1,223	39	1,223		5,121	44
45	ALARM SYSTEM UPGRADE	2001	57,107	1,464	39	1,464		5,661	45
46	PARKING LOT PAVING	2001	25,000	1,668	15	1,668		5,837	46
47	CARPET TILE INSTALLATION	2002	3,429	88	39	88		246	47
48	DOORS/DOOR REFINISHING	2002	149,707	3,838	39	3,838		9,929	48
49	SINK PARTS/FAUCETS	2002	8,482	217	39	217		461	49
50	ROOF REPLACEMENT	2002	38,000	974	39	974		2,070	50
51	FIRE REG UPGRADE-DAMPERS/DRYWALL/DOORS/LAUNDRY	2003	38,757	994	39	994		1,473	51
52	CONDENSING UNIT	2004	3,396	40	39	40		40	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60	*LINE 12 - ITEM FROM 1984 TOTALLING $33,981 RESULTS FROM A PRIOR AUDIT AND IS NOT REFLECTED ON THE BALANCE SHEET.								60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,334,910	$ 45,973		$ 103,598	$ 57,625	$ 2,486,703	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 939,811	$ 63,503	$ 73,749	$ 10,246	3-20 YRS	$ 541,025	71
72	Current Year Purchases	19,872	3,148	820	(2,328)	8-15 YRS	820	72
73	Fully Depreciated Assets	129,263				3-20 YRS	129,263	73
74								74
75	TOTALS	$ 1,088,946	$ 66,651	$ 74,569	$ 7,918		$ 671,108	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN	SPORTVAN '86	1985	$ 19,262	$	$	$	4 YRS	$ 19,262	76
77	ADMIN/ETC	SAAB '01	2001	39,868	1,775	9,967	8,192	4 YRS	34,885	77
78	" "	MERCEDES '05	2004	77,977	2,960	9,747	6,787	4 YRS	9,747	78
79										79
80	TOTALS			$ 137,107	$ 4,735	$ 19,714	$ 14,979		$ 63,894	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,722,146	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,359	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 197,881	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 80,522	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,221,705	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 22,270 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN,ETC	2003 MERCEDES	$ 907.38	$ 10,409	17
18		TOTAL NET OF PAYROLL DEDUCTION			18
19					19
20					20
21	TOTAL		$ 907.38	$ 10,409	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 216,665	$		$ 216,665	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			88,444			88,444	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			221,464			221,464	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				147,820		147,820	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB / RADIOLOGY	39-2					4,586		4,586	13
14	TOTAL			$		$ 526,573	$ 152,406		$ 678,979	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 925,416	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 585,000)	1,160,250		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	292,000		5
6	Prepaid Insurance	177,155		6
7	Other Prepaid Expenses	74,221		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INSUR/R.E.TAX ESCROW	199,493		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,828,535	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	161,183		13
14	Buildings, at Historical Cost	2,290,723		14
15	Leasehold Improvements, at Historical Cost	1,010,208		15
16	Equipment, at Historical Cost	1,226,053		16
17	Accumulated Depreciation (book methods)	(3,114,974)		17
18	Deferred Charges	57,467		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): REPLACEMENT RESERVE	379,702		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,010,362	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,838,897	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 471,113	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	165,955		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,818		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,166		31
32	Accrued Real Estate Taxes(Sch.IX-B)	274,940		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,000		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,072,992	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,770,175		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,770,175	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,843,167	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,995,730	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,838,897	$	48

*(See instructions.)

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,270,184	1
2	Restatements (describe):		2
3			3
4	ROUNDING	7	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,270,191	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(111,284)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(163,177)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (274,461)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,995,730	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,800,777	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,800,777	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	485,637	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 485,637	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,355	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,355	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,297,769	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,764,374	31
32	Health Care	3,072,818	32
33	General Administration	2,211,572	33
	B. Capital Expense		
34	Ownership	522,607	34
	C. Ancillary Expense		
35	Special Cost Centers	678,979	35
36	Provider Participation Fee	134,506	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	14,197	37
38	SETTLEMENT EXPENSE	10,000	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,409,053	40
41	**Income before Income Taxes (line 30 minus line 40)****	(111,284)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (111,284)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,603	4,092	$ 130,668	$ 31.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,136	14,929	347,628	23.29	3
4	Licensed Practical Nurses	40,460	47,072	949,977	20.18	4
5	Nurse Aides & Orderlies	128,132	139,655	1,190,159	8.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,261	1,528	17,347	11.35	8
9	Activity Director					9
10	Activity Assistants	8,149	9,320	101,098	10.85	10
11	Social Service Workers	6,556	7,238	104,751	14.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,442	40,711	364,036	8.94	15
16	Dishwashers					16
17	Maintenance Workers	20,099	22,366	211,387	9.45	17
18	Housekeepers	9,715	11,041	83,557	7.57	18
19	Laundry	14,068	15,905	128,351	8.07	19
20	Administrator	1,973	2,073	148,049	71.42	20
21	Assistant Administrator	3,776	4,097	149,443	36.48	21
22	Other Administrative	2,061	2,085	55,247	26.50	22
23	Office Manager	1,921	1,981	138,078	69.70	23
24	Clerical	8,189	8,753	135,994	15.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,396	1,671	17,739	10.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	300,937	334,517	$ 4,273,509 *	$ 12.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 17,720	1-3	35
36	Medical Director	O	4,800	9-3	36
37	Medical Records Consultant	N	3,640	10-3	37
38	Nurse Consultant	T	9,023	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	1,594	10a-3	40
41	Occupational Therapy Consultant	Y	1,939	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,716		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAMELA ORR	ADMINISTRATOR	**	$ 148,049
MARJORIE MARTIN	ADMINISTRATIVE	**	55,247
ALLEN SPIFF	ASST ADMIN	0.00%	47,794
ROBYN MARTIN	ASST ADMIN	**	101,649
	** BY ATTRIBUTION 100%		
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 352,739

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		165,303
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 165,303

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,954
Unemployment Compensation Insurance	67,567
FICA Taxes	317,741
Employee Health Insurance	430,665
Employee Meals	68,954
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	11,840
EMPLOYEE PHYSICAL EXAMS	101
PENSION/PROFIT SHARING PLANS	16,324
CHICAGO HEAD TAX	10,520
INSURANCE - EXECUTIVE LIFE	2,640
INSURANCE - EXECUTIVE LIFE VI 21	(2,640)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,027,666

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,238
Health Care Worker Background Check	704
(Indicate # of checks performed 44)	
MARKETING/ADV/PROMO	15,083
TRUST/FRANCHISE/CONTRIB/ETC	8,307
LICENSES & PERMITS	3,502
DUES & SUBSCRIPTIONS	13,312
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(8,307)
Less: Public Relations Expense	(4,119)
Non-allowable advertising	(2,891)
Yellow page advertising	(8,073)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,756

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORAT'C	2004	$ 3,911	3	$	$	$	$ 652	$ 1,304	$ 1,304	$ 651	$	$
2													
3													
4													
5													
6													
7													
8													
9													
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18													
19													
20	TOTALS		$ 3,911		$	$	$	$ 652	$ 1,304	$ 1,304	$ 651	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $9,773**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,233** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **134,506**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **68,954** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? **5%**

d. Have vehicle usage logs been maintained? **NO**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**

g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **FROST RUTTENBERG & ROTTHBLATT** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees